9 Months Old — AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS : ☐ yes ☐ no	PEDS Pathway:	Birth Wt:	Allergies:	Temp:	Pulse:	Resp:

Risk indicators of hearing loss: ☐ yes ☐ no	Medications:	Wt:	%	Length:	%	Head circ:	%

PARENTAL CONCERNS/HISTORY:

VERBAL LEAD RISK ASSESSMENT: [X] INDICATES GUIDANCE GIVEN: At risk ☐ yes ☐ no (if yes, a blood lead test is required)

ORAL SCREENING: [X] INDICATES GUIDANCE GIVEN: ☐ Brushing teeth ☐ White spots on teeth

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Adequate intake ☐ Breast fed ☐ Formula: _____ ☐ Soda/Juice ☐ Solids ☐ Supplements:

DEVELOPMENTAL SCREEN: ☐ Goes from sitting to all fours ☐ Peek-a-boo ☐ Uses words such as "mama/dada" ☐ Sits independently ☐ Repeats sounds/gestures for attention ☐ Explores environment ☐ Waves bye-bye ☐ Drinks from cup ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Drowning prevention ☐ Emergency 911 ☐ Sun Safety ☐ Baby proofing ☐ Car seat/rear facing ☐ Sleep/wake cycle ☐ Wary of strangers ☐ Introduce board books ☐ Soft texture finger foods/choking ☐ Redirection/positive parenting ☐ Exploration/learning ☐ Passive smoke ☐ Language/read to child ☐ Follow child's lead in play ☐ Parent communicates to child "what things are"(ball, cat etc) ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family Adjustment/parent responds positively to child ☐ Encourage holding ☐ Self calming ☐ Growing Independence ☐ Shows preference for certain people/toys ☐ Cries when primary care giver leaves ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: [X] INDICATES ORDERED ☐ Hgb/Hct **(perform at 9 months)** ☐ Other

IMMUNIZATIONS: [X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ Hepatitis B ☐ DTaP ☐ Hib ☐ IPV ☐ PCV ☐ Influenza ☐ Other

REFERRALS: [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ Speech ☐ AzEIP/DDD ☐ Developmental ☐ Behavioral ☐ Early Head Start ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐**Yes** ☐**No**